MERCER
Human Resource Consulting

Final

June 22, 2005

County of San Diego
Acute & Long-Term Care Integration Project (ALTCI) — Information Technology Assessment
Findings and Recommendations

MMC Marsh & McLennan Companies

Contents

I. Introduction

Introduction
Project Objectives

- San Diego ALTCI believes that an integrated health information system accessible by long-term care (LTC) consumers, providers, advocates, state, and county agencies and health plans will improve:
  - coordination of social support services;
  - clinical management and health care delivery;
  - the overall quality of life for the LTC clients they serve;
  - billing and financial operations, while promoting cost savings; and
  - supportive services for San Diego County ALTCI administrative processes.
- The objectives of this information technology assessment are:
  - measure ALTCI stakeholders' current capabilities to access/conduct electronic data transactions;
  - solicit feedback on future needs of the various stakeholders;
  - understand the basics of the current health information integration practices of local, regional, state, and national health information organizations or networks; and
  - develop and prioritize next steps for the County of San Diego to initiate, in relation to development of an integrated information technology (IT) system to support the ALTCI program within the Healthy San Diego Plus strategy.

Introduction
Methodology

Custom Surveys

- Developed unique surveys for each of the four stakeholder groups (consumer/advocates, providers, agencies, and health plans), which were sent to 598 individuals and organizations.
- Surveys emphasized assessing status of current Internet access and usage, electronic exchange of data, current systems capabilities, and future needs.
- Findings were compiled and analyzed collectively and by stakeholder group.

Current Health Information Integration Practices

- Information collection and/or interviews were conducted with:
  - local integrated provider networks and the California Regional Health Information Organization (CalRHIO); and
  - two other state LTC agencies with integrated health care delivery systems.
- Findings were compiled and analyzed.

Recommendations

- Recommendations and an action plan for the development of an integrated health information system were developed.

II. Advocate/Consumer Survey Findings

Consumer/Advocate Survey Findings Purpose and Responses

Purpose

- Determine the availability of Internet access, types of current use, and desired future uses by San Diego LTC consumers and advocates.

Responses

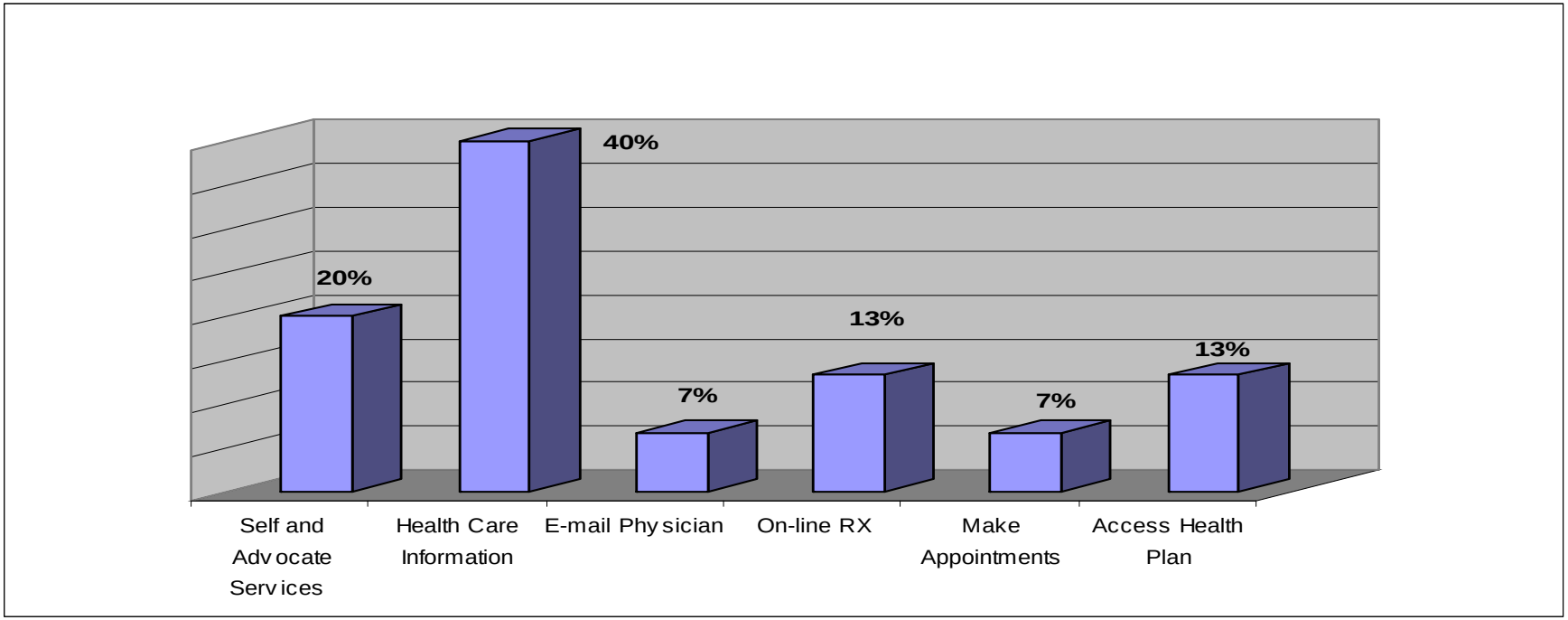
- Survey Distribution:
  - distributed electronically to 275 consumers and advocates on April 14, 2005; and
  - hard copies were made available at the San Diego County LTCIP Stakeholders Meeting on April 13, 2005.
- 6.5% (18) of the 275 consumers/advocates responded***:**
  - 10 were returned electronically; 8 by mail.

* ***Due to the small sample size of returned responses, findings should be considered as guidelines and not statistically-significant.***

Consumer/Advocate Survey Findings Current Access to Data/Information

Findings (18 Respondents)

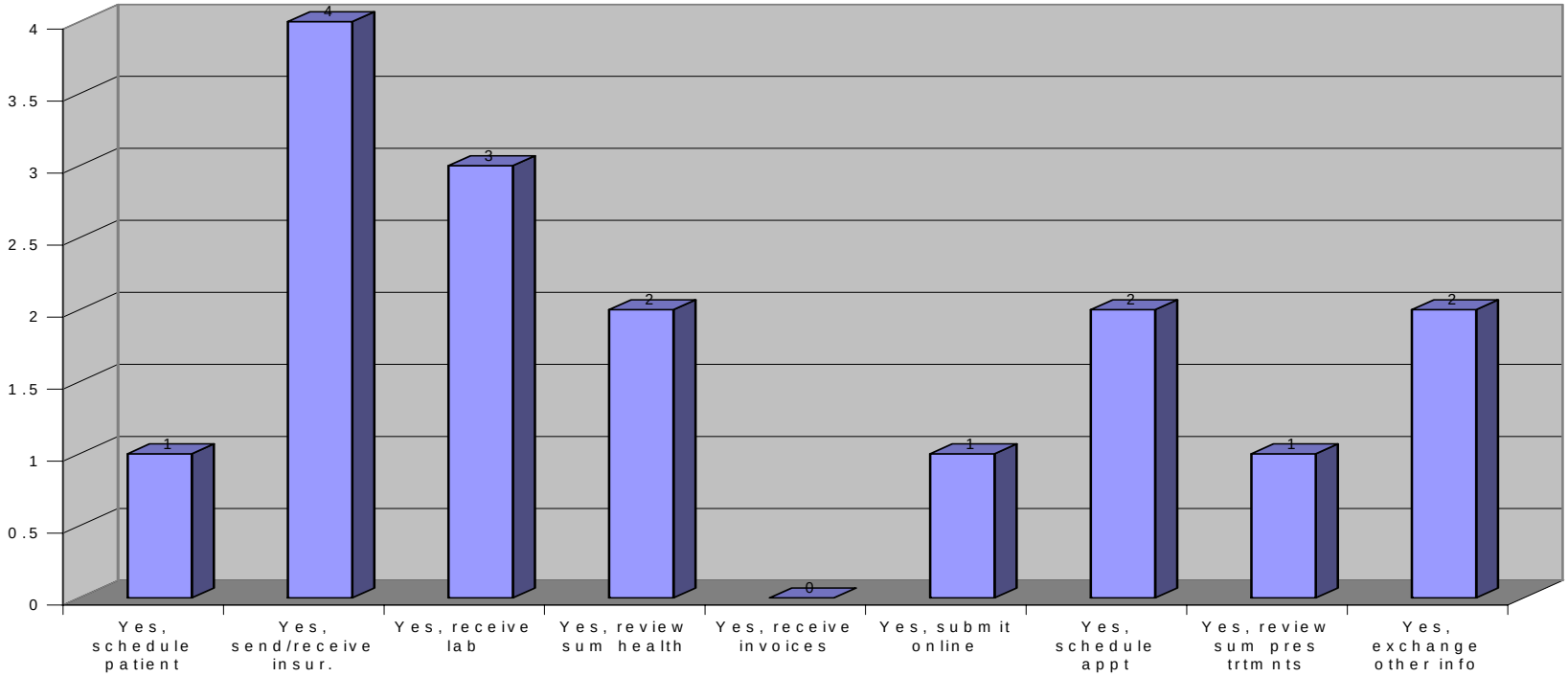
- 94% of the consumers/advocates surveyed responded that they have access to the Internet.
- 72% of the consumers/advocates surveyed indicated that they receive or access electronic information regarding their health care or other support services. These services include:



Consumer/Advocate Survey Findings Current Access to Data/Information

Findings — continued

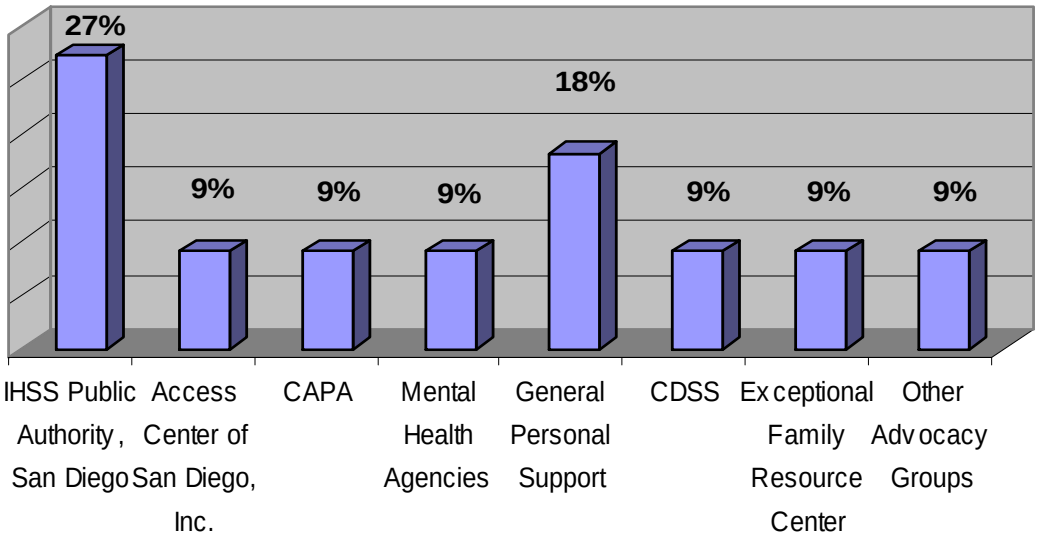
- 71% indicated that they seek health care or other health-related information via the Internet.
- 71% of the respondents also indicated that they exchange information with their health care providers via e-mail or the Internet. This information included:



Consumer/Advocate Survey Findings Current Access to Data/Information

Findings — continued

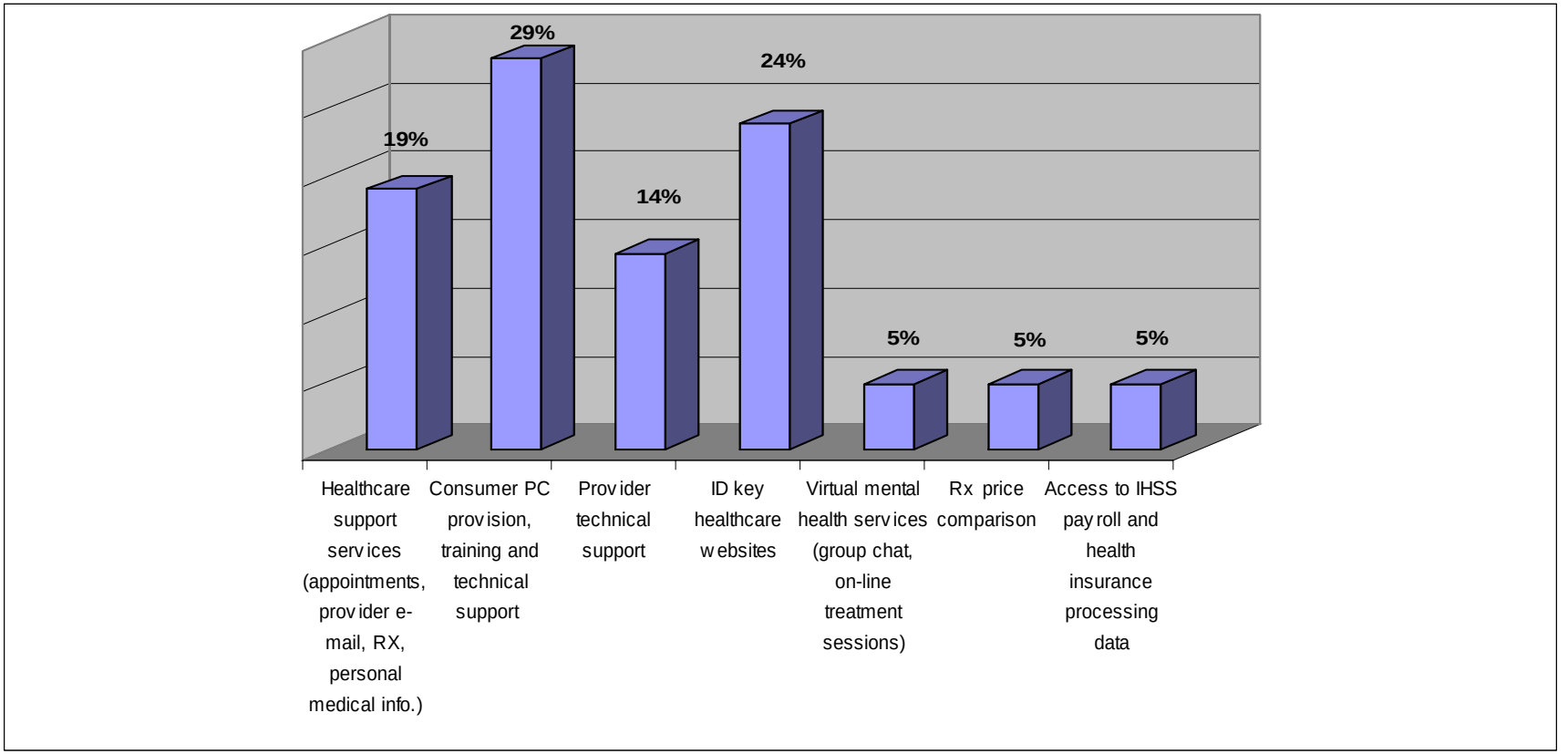
- However, only 38% replied that they exchange information via e-mail or the Internet for social support services. This information included:



Consumer/Advocate Survey Findings
Future Access to Data/Information

Findings — continued

- 78% of consumer/advocate survey respondents indicated that the Internet could support better health care and support services in the following ways:



Consumer/Advocate Survey Findings
Summary of Major Findings

Summary of Major Findings From Consumer/Advocate Responders*:

- The vast majority of consumers and advocates have Internet access.
- A majority use the Internet to access and/or exchange health care or support services.
- A majority of the responders access and/or exchange health care information with providers.
- Significantly fewer (38% of responders) receive and/or exchange support services information via the Internet.
- A large majority believe that health care and support services could be improved if PCs, training, and technical support were made available to consumer/advocates.

* ***Due to the small sample size of returned responses, findings should be considered as guidelines and not representative of all consumer/advocates of LTC services.***

III. Provider Survey Findings

Provider Survey Findings
Purpose and Responses

Purpose

- Determine the availability of Internet access, types of electronic data, and information currently exchanged; current electronic health/medical record systems utilized and future needs and uses by San Diego County LTC providers.

Responses

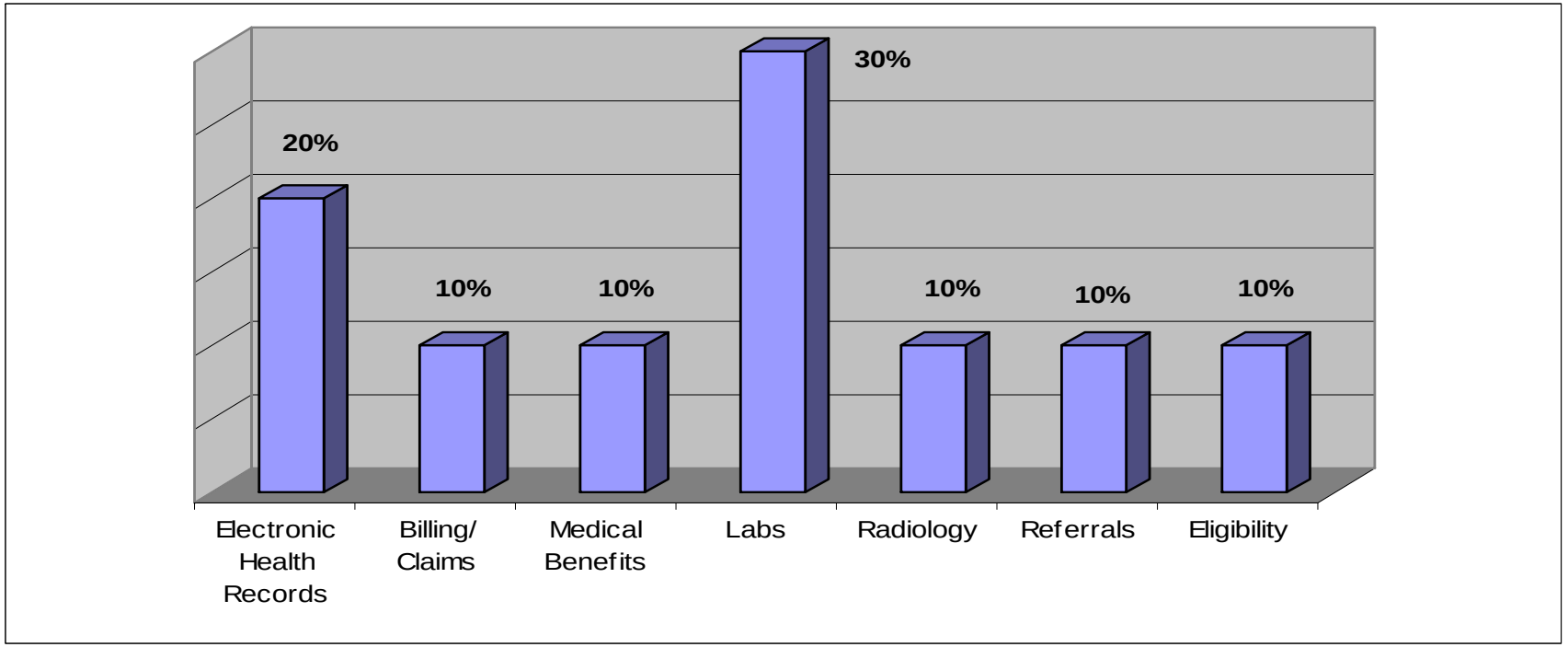
- Survey Distribution:
  - providers were defined as those who provided LTC services;
  - distributed electronically to 295 providers and agencies on April 15, 2005; and
  - hardcopies were made available at the San Diego County LTCIP Stakeholders Meeting on April 13, 2005.
- 18% (53) of the 295 providers and agencies responded*****:
  - 36 were completed by providers; and
  - 9 were received electronically; 27 by mail.

* ***Due to the small sample size of returned responses, findings should be considered as guidelines and not statistically-significant.***

Provider Survey Findings
Current Access to Data/Information

Findings (36 Respondents)

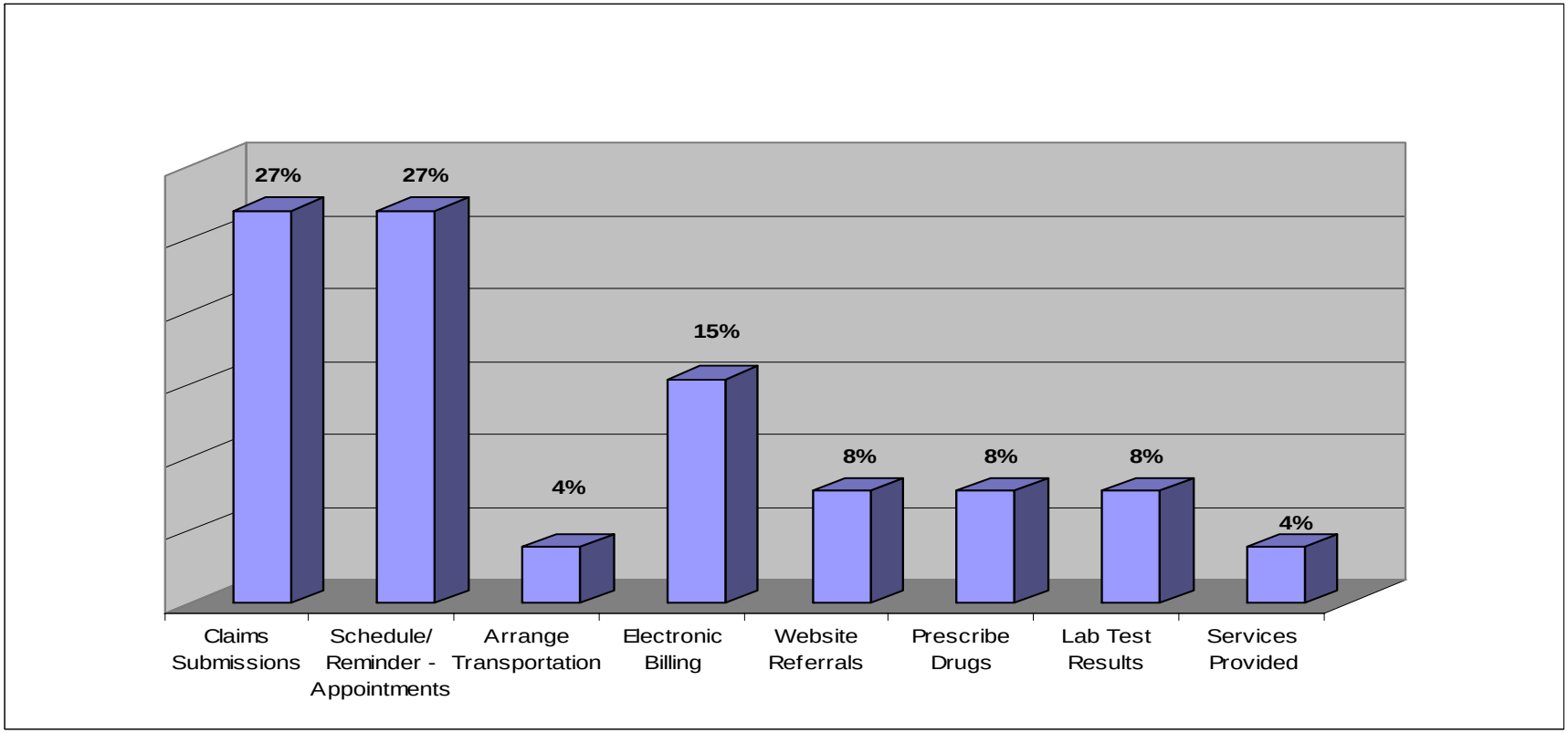
- 75% of the providers surveyed responded that they have office access to the Internet.
- 61% of the providers indicated that they receive or have access to electronic patient information. This information includes:



Provider Survey Findings
Current Access to Data/Information

Findings — continued

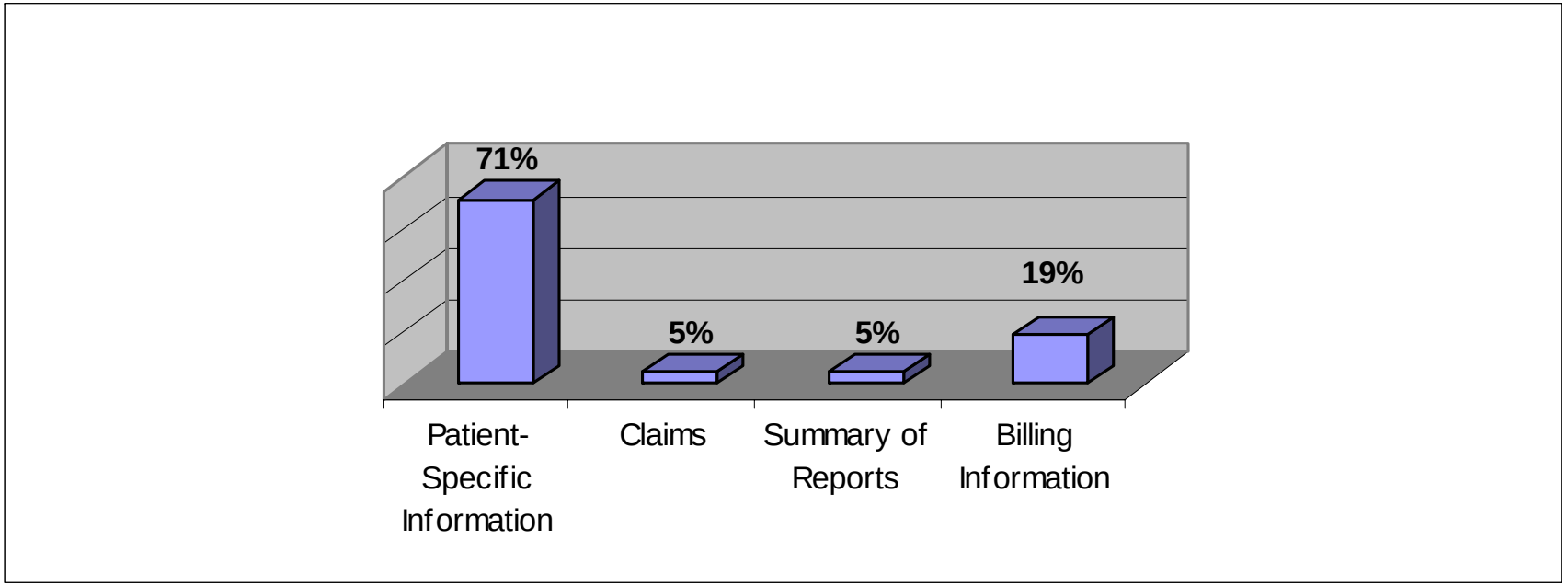
- 56% indicated that they schedule patient appointments, or distribute patient or provider information via electronic means. This information includes:



Provider Survey Findings
Current Access to Data/Information

Findings — continued

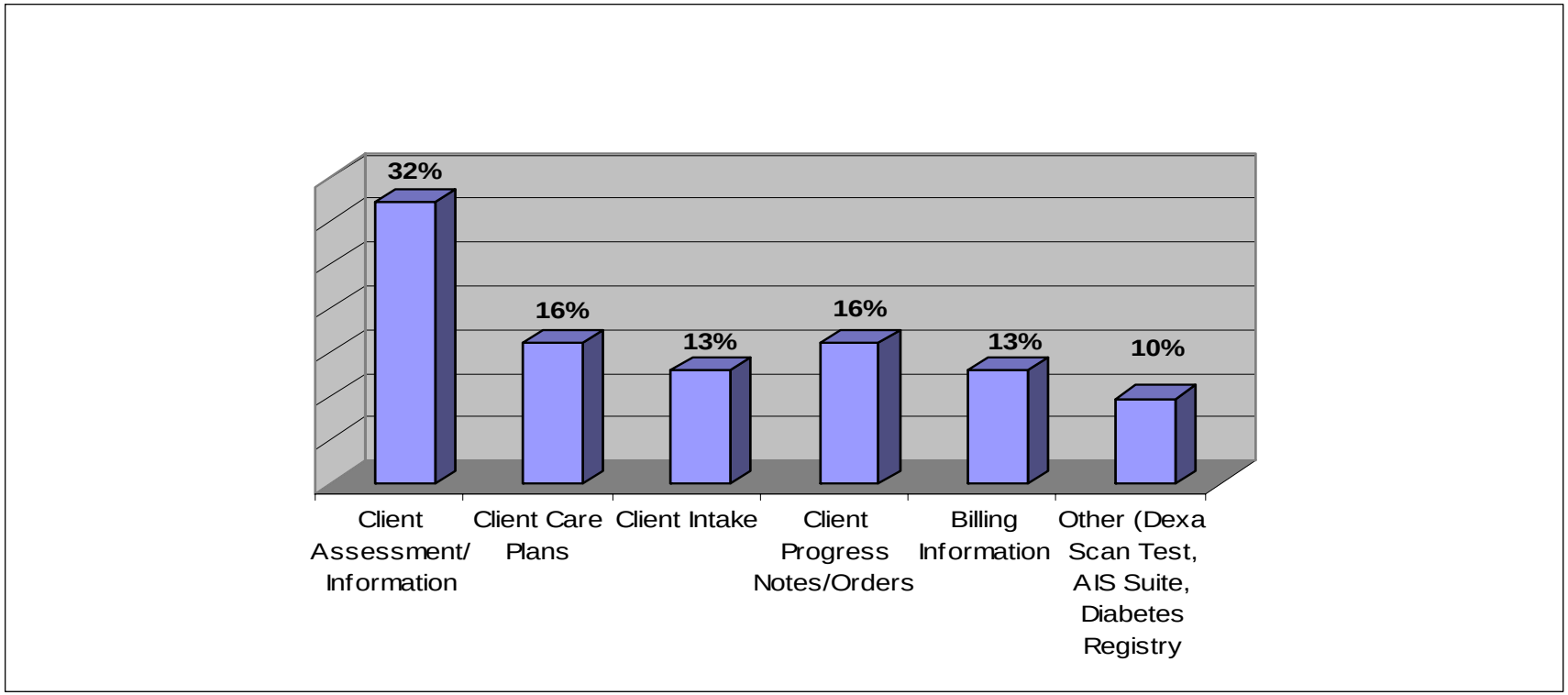
- 56% of the providers replied that they store the electronic information or data described on the previous slide in electronic databases. This information is stored as:



Provider Survey Findings
Current Data or Information Systems

Findings — continued

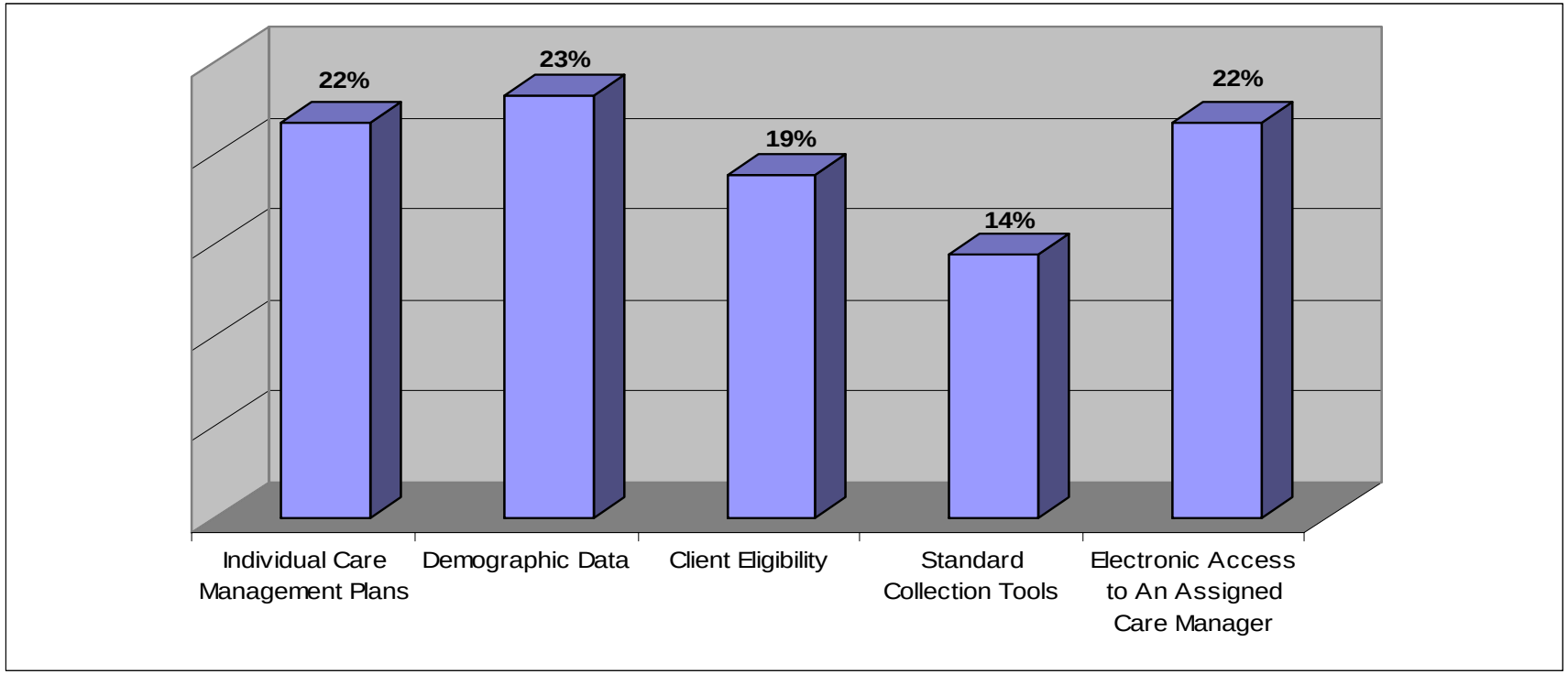
- 57% of the providers replied that they maintain electronic files, health records, databases, or information systems related to aging or LTC clients. The electronic files maintained include the following:



Provider Survey Findings
Future Access to Electronic Data or Information

Findings — continued

- 71% of the providers surveyed replied that they would utilize electronic means to access patient data or information for LTC clients if there was a centralized electronic source. The most important information or data to access was reported by providers as follows:



Provider Survey Findings
Summary of Major Findings

Summary of Major Findings From Provider Respondents*:

- A majority of providers have Internet access.
- A majority have access to electronic patient information, primarily lab data:
  - this is consistent with the responses from consumers/advocates.
- A small majority (56%) conduct administrative services via electronic means (primarily claims submission and appointment scheduling/send reminders).
- A similar majority store electronic patient health information primarily as patient-specific data (client assessment, progress notes, and demographics).
- A large majority would utilize a centralized source of electronic LTC patient data for managing delivery of patient care. The most important functionality desired included access to:
  - individual care management plans, demographic data, client eligibility, standard collection tools (such as eligibility forms, etc.), and care management via electronic access.

* ***Due to the small sample size of returned responses, findings should be considered as guidelines and not representative of all providers of LTC services.***

IV. Agency Survey Findings

Agency Survey Findings
Purpose and Responses

Purpose

- Determine the availability of Internet access, types of electronic data, and information currently exchanged, including exchange with sister agencies; current electronic health/medical record systems utilized and desired future needs and uses by San Diego County LTC agencies.

Responses

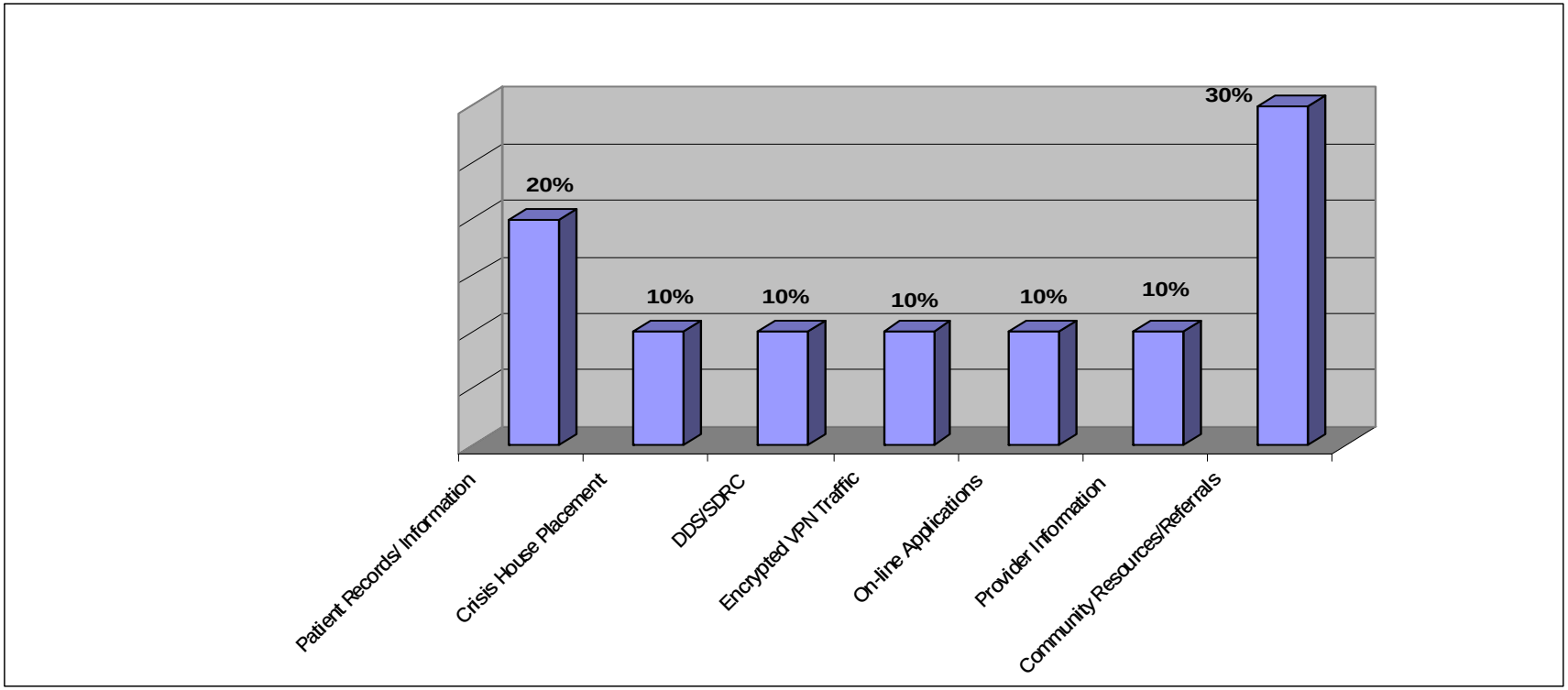
- Survey Distribution:
  - agencies were defined as those state, county, and municipal government/public entities that arranged or provided LTC services;
  - distributed electronically to 295 providers and agencies on April 15, 2005; and
  - hardcopies were made available at the San Diego County LTCIP Stakeholders Meeting on April 13, 2005.
- 18% (53) of the 295 providers and agencies responded***:**
  - 17 were completed by agencies; and
  - 8 were received electronically; 9 by mail or fax.

* ***Due to the small sample size of returned responses, findings should be considered as guidelines and not statistically-significant.***

Agency Survey Findings
Current Access to Data/Information

Findings (17 Respondents)

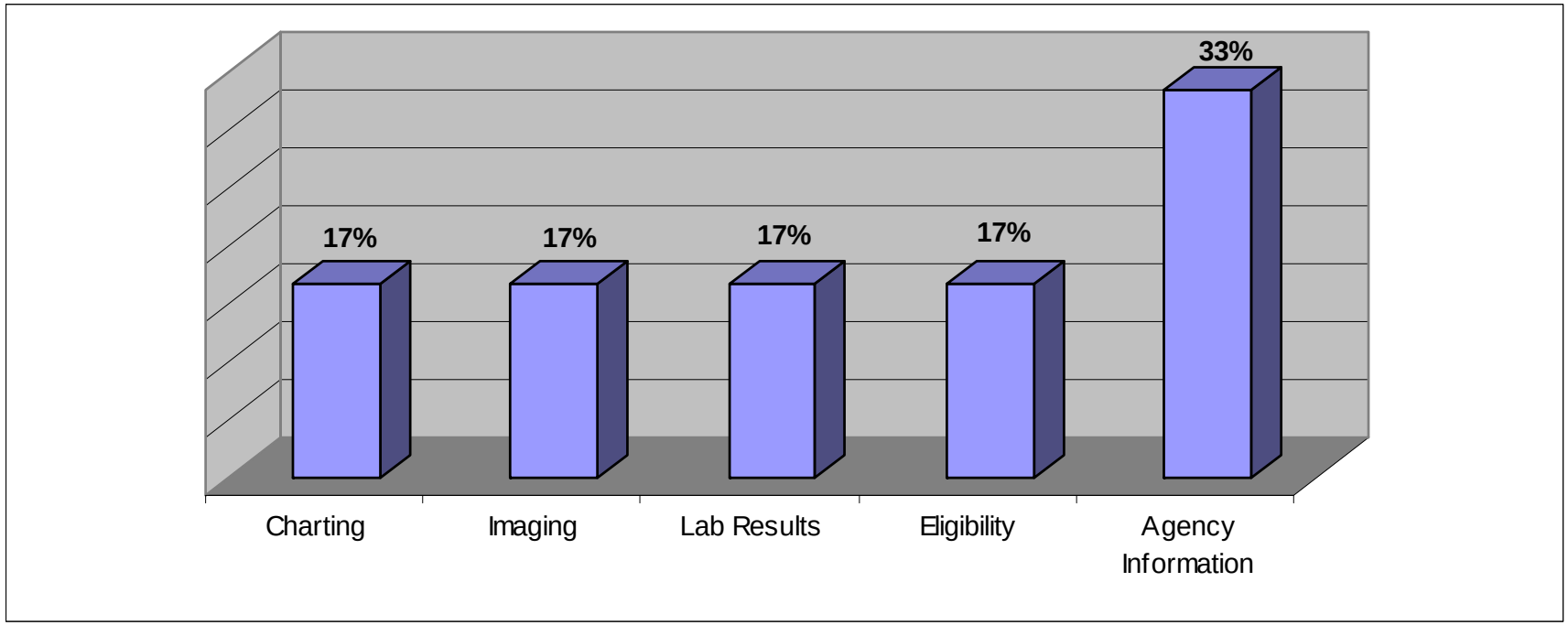
- 53% of the agencies surveyed responded that they have access to the Internet. The information received or distributed includes:



Agency Survey Findings
Current Access to Data/Information

Findings — continued

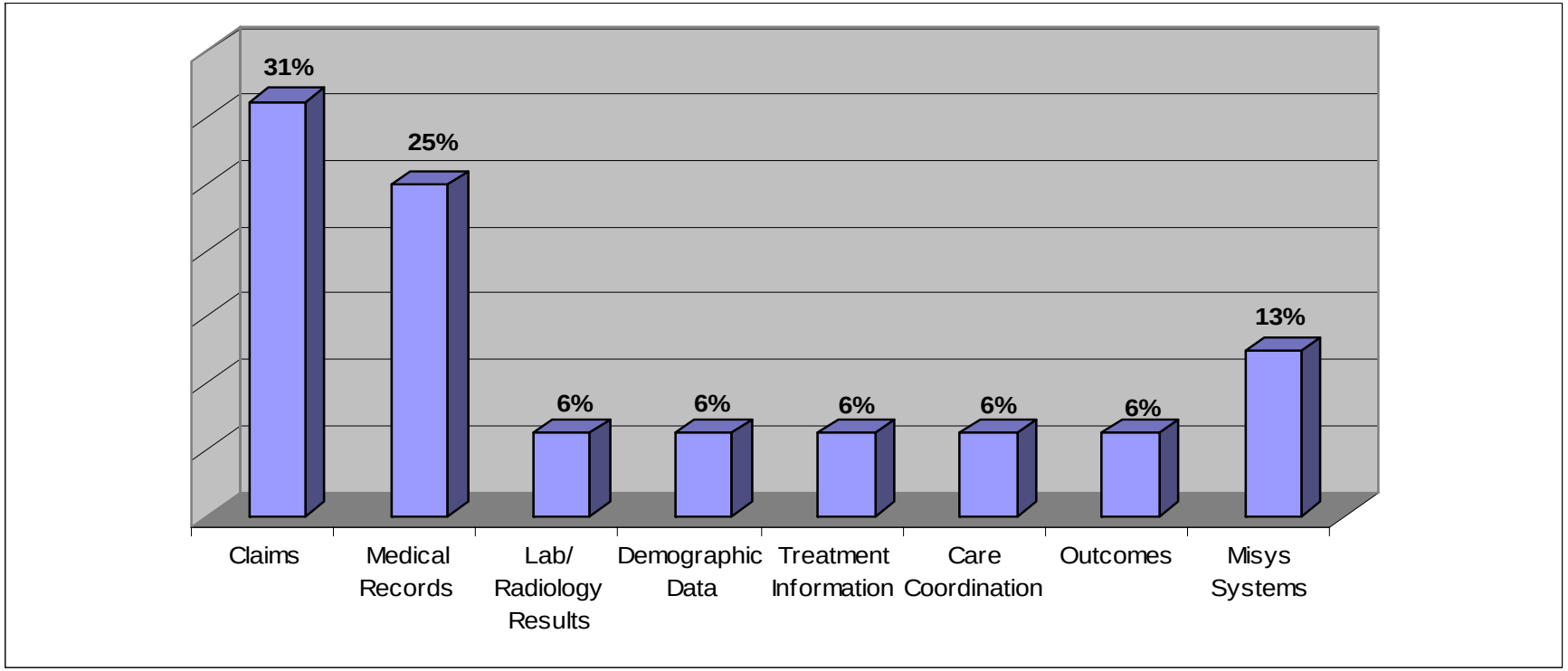
- 25% of the responding agencies indicated that they have access to other sister agencies' patient or provider information. This information includes:



Agency Survey Findings
Current Access to Data/Information

Findings — continued

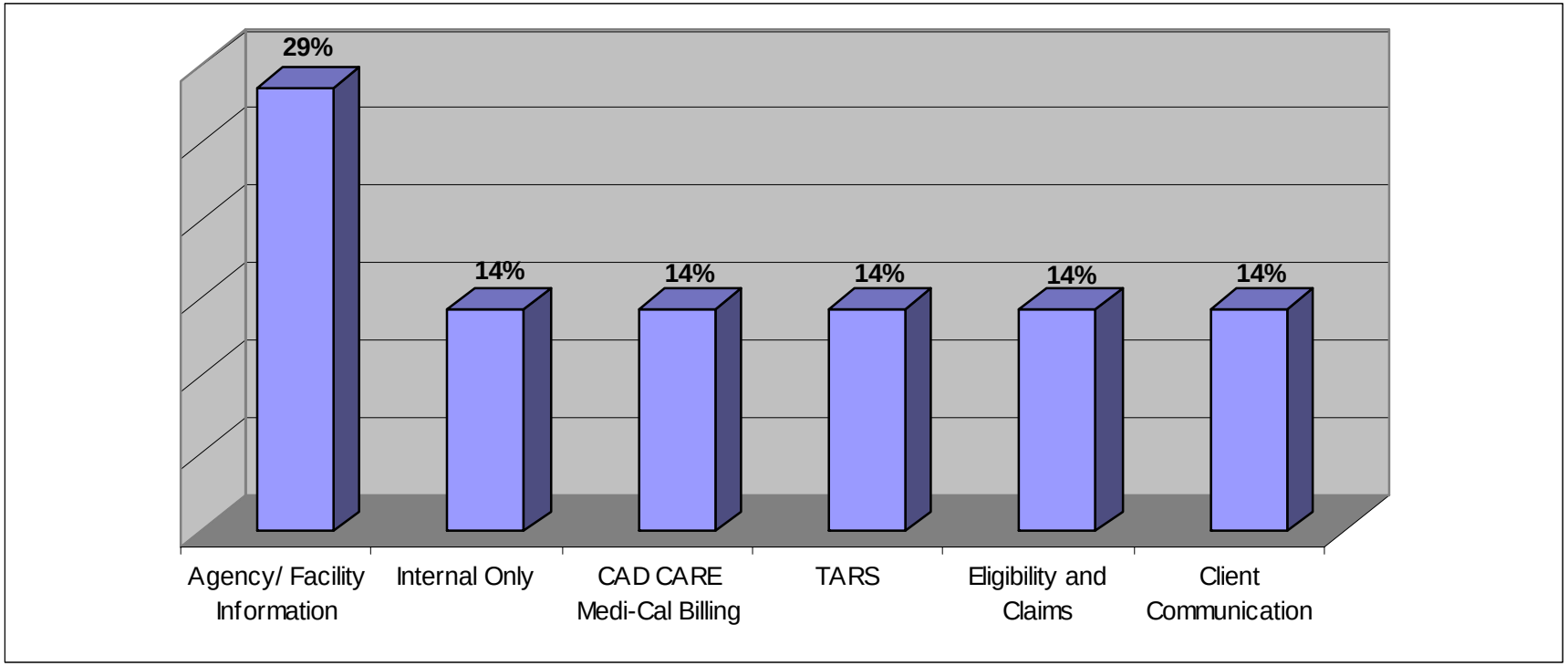
- 56% of the responding agencies indicated that they receive or have access to patient information via an electronic source. This information includes:



Agency Survey Findings
Current Access to Data/Information

Findings — continued

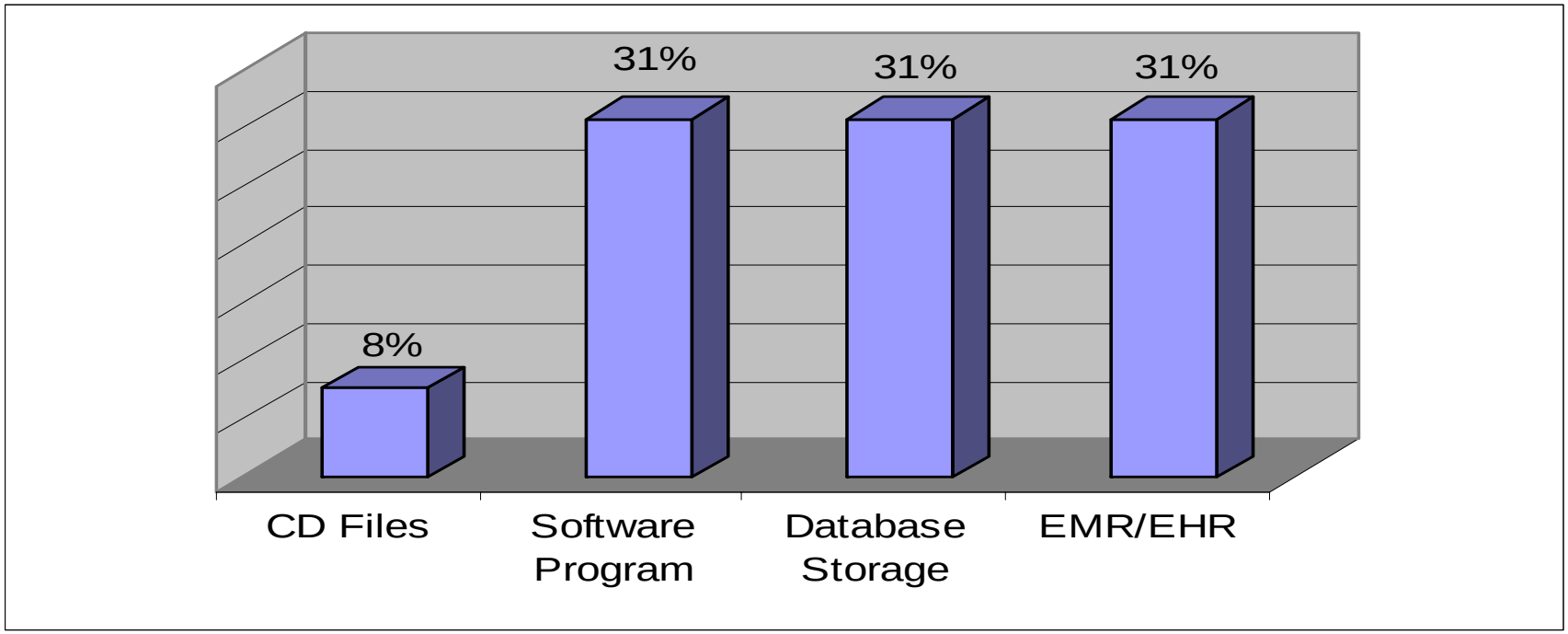
- 38% of the responding agencies replied that they distributed patient or provider information via an electronic means. The information that these agencies distributed electronically includes:



Agency Survey Findings
Current Access to Data/Information

Findings — continued

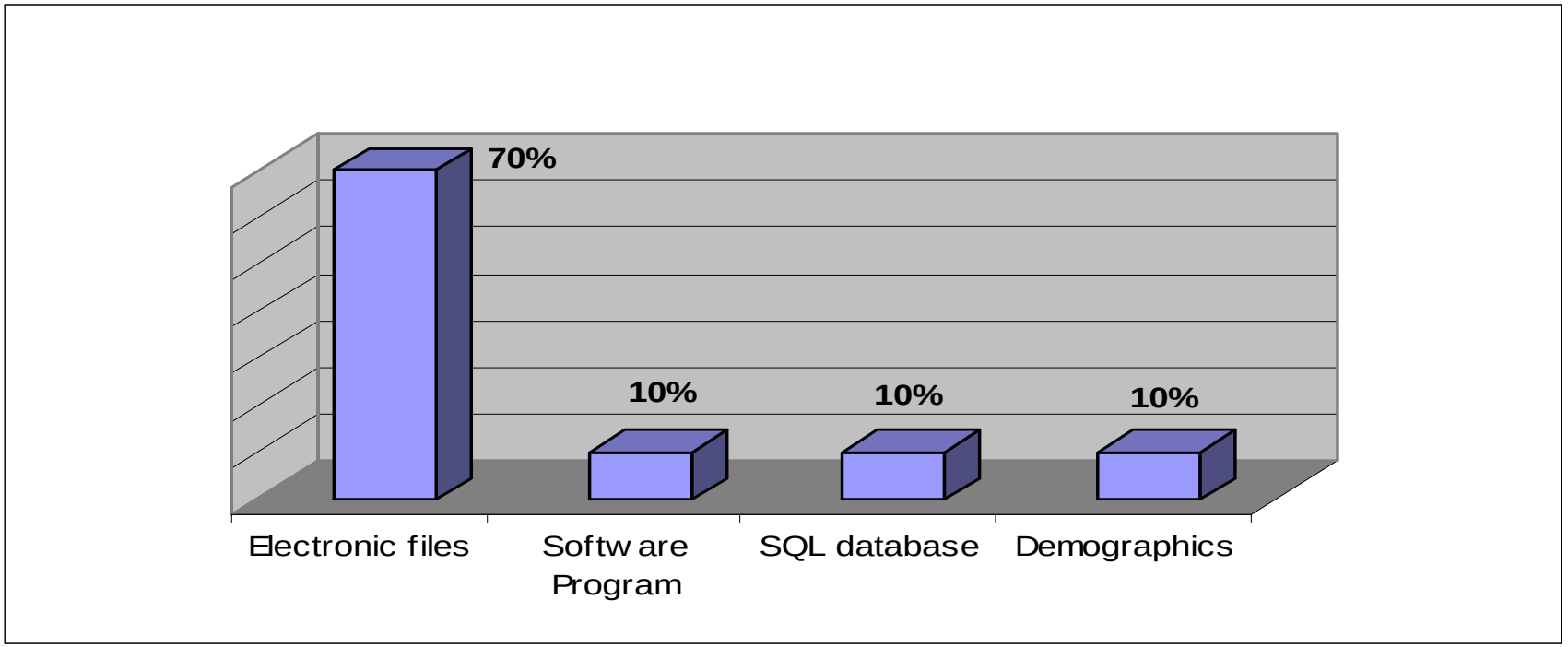
- 82% of the responding agencies replied that they store the electronic information or data described on the previous slide in electronic databases. This information is stored as:



Agency Survey Findings
Current Data or Information Systems

Findings — continued

- 62% of the responding agencies replied that they maintain electronic files, health records, databases, and systems related to aging and LTC clients. This information is stored as:



Agency Survey Findings
Future Uses/Access to Electronic Data or Information

Findings — continued

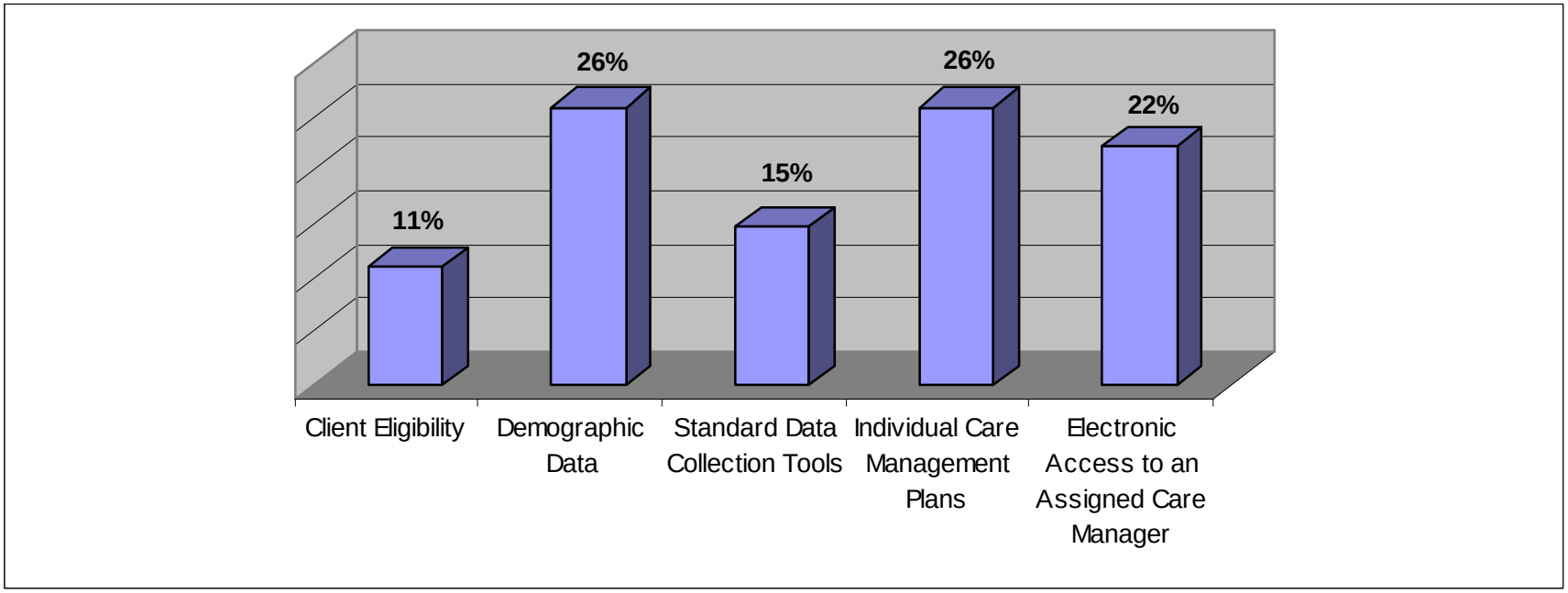
- 78% of the responding agencies replied that they would benefit from an electronic centralized source of patient, provider, or other types of LTC client data that provided key information. They listed the most important information to access as:

Demographic data (6)	**SNF bed capacity (1)**
EHR/EMR, or other patient records (3)	**LTC providers (1)**
Insurance information (1)	**Vendor reports (1)**
Improved medical services procurement system (1)	**Treatment authorization information (1)**
Comprehensive LTC knowledge and information-sharing site (1)	

Agency Survey Findings
Future Uses/Access to Electronic Data or Information

Findings — continued

- 73% of the responding agencies replied that they would use electronic reports, formatted information, and data collection tools if they had access to a centralized source. They listed the most important information to access as:



Agency Survey Findings
Summary of Major Findings

Summary of Major Findings From Agency Responders*:

- Only a little over half (53%) have access to the Internet.
- Approximately one third of those with access use electronic means to access community resources and for referrals.
- There is very little (25%) interagency electronic interchange.
- A slim majority have access to electronic patient information:
  - this is primarily to claims records and some medical records.
- A few agencies distribute patient or provider information via electronic means, predominately materials include agency or facility information.
- A large majority store electronic data in databases or systems:
  - a large number of agencies store LTC data and information electronically.
- A majority stated that they would benefit from a centralized electronic source for demographic data and patient records:
  - useful tools would include demographic data, care management plans, and care manager files; and
  - this is consistent with the provider responses.

* ***Due to the small sample size of returned responses, findings should be considered as guidelines and not representative of all LTC agencies.***

V. Health Plan Survey Findings

Health Plan Survey Findings
Purpose and Responses

Purpose

- Determine the availability of shared access, data exchange, type, quality, and available ancillary data systems of health plans who are potential partners of Healthy San Diego Plus.

Responses

- Survey Distribution:
  - distributed electronically to 9 health plans on April 25, 2005.
- 22% (2) of the 9 health plans (all Healthy San Diego Plus contractors and 3 other potential partners) responded***:**
  - 2 were returned electronically, neither from a current Healthy San Diego Plus contractor.

* ***Due to the very small sample size of returned responses, findings should be considered as guidelines and not representative of all servicing health plans.***

Health Plan Survey Findings
Shared Data and External Access

Currently Shared Data and External Access

- Both responding health plans offer web-based access to members and providers;
  - one offers on-line access to benefits summary; and
  - the second plan provides internet portals, as well as voice-enabled access for enrollee eligibility, benefits, and claim submission and status.
- Both responding health plans believe that LTC consumers, providers, and members would best be served by sharing member-approved health information, medical records, eligibility, benefits, claim status, and servicing provider information.
- Both responding plans believe that access should be via an Internet portal and should be robust and easy to use.

Health Plan Survey Findings
External Outbound Data Exchanges

External Outbound Data Exchanges

- Both responding health plans are able to send electronic claims data in the standard formats adopted by the federal Department of Health and Human Services (HHS) for the exchange of clinical information*, and neither uses proprietary codes:
  - however, the responding health plans currently submit varying data files to different external federal and state agencies and vendors.
- Both responding plans use auxiliary systems and databases for data storage.
- One of the responding plans verifies and validates claims data, while the second plan does not.
- Both plans are able to send eligibility data, while the larger plan is also sending third party liability (TPL)/coordination of benefits (COB), provider network/specialty, billing, enrollee demographic data, and provider data to providers.

* ***On May 4, 2004, HHS adopted the Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets for electronic exchange of health-related information to perform billing or administrative functions as the standard for use in federal technology systems.***

Health Plan Survey Findings
Inbound Data Exchanges and Capitation

Inbound Data Exchanges and Capitation

- Both responding health plans have core claims processing systems that have undergone changes that have resulted in improved quality of the data.
- Both responding health plans have the capacity to retain data and report on it for 7 years, while the larger plan has indefinite capacity.
- Both plans conduct regular claims data audits and have processing timeliness results that are within federal and state requirements.
- The larger of the two responding plans uses multiple systems for claims processing and conducts monthly audits to assure quality, accuracy, and timeliness of processing:
  - both plans conduct routine and ad-hoc audits on claims data to assure quality, accuracy, and timeliness of processing.
- The smaller of the 2 responding plans also electronically receives and stores hospital census counts.

Health Plan Survey Findings
Ancillary Systems

Ancillary Systems

- The larger of the 2 responding plans adjudicate distinct lines of benefits through a separate system. These benefit categories include:
  - pharmacy services,
  - behavioral health,
  - vision, and
  - dental.
- The larger plan also manages provider network, vendor claims data, and various management oversight reports via a separate system.
- The larger of the two responding plans also has a separate system that houses real-time enrollee information in an integrated database, as well as a separate clinical case management system:
  - synchronized interfacing takes place between these ancillary systems and the core claims management system to allow up-to-date integration; and
  - the enrollee information contained in the system includes enrollee eligibility data, demographic data, provider data, authorization, and assessment data.

Health Plan Survey Findings
Summary of Major Findings

Summary of Major Findings From Health Plan Responders*:

- The health plans use the HHS standards for transactions and code sets for electronic exchange of health-related information to perform billing or administrative functions in federal technology systems.
- Both plans are capable of sending and receiving electronic claims and eligibility data in the above standard formats.
- The quality of the electronic claims data is presumably strong, due to quality, accuracy, and timeliness audits.
- The larger health plan also stores subcontracted vendor data.

* ***Due to the small sample size of returned responses, findings should be considered as guidelines and not representative of all of LTC health plans.***

VI. Data Alliances Interviews and RHIO Findings, including San Diego MINE Initiative

Data Alliances and RHIOs Background

Background

- Federal
  - April 2004 Executive Order 1335 required
    - Extensive adoption of interoperable (EHRs) within 10 years.
    - The Office of the National Coordinator for Health Information Technology (ONCHIT) be created in the HHS agency:
      - Three goals were established:
        1. Interconnect clinicians by creating interoperability through:
           a. regional health information exchanges;
           b. national health information infrastructure; and
           c. coordinating federal health information systems.
        2. Personalize care by:
           a. promoting personal health records;
           b. providing information about providers to promote choice; and
           c. facilitating tele-medicine in rural and underserved areas.

Data Alliances and RHIOs Background

Background (continued)

3. Improve population health by:
   a. centralizing public health surveillance;
   b. streamline quality of care monitoring; and
   c. promote evidence-based research and outcomes use.

– The Federal Health Architecture (FHA)

- In collaboration with the Consolidated Health Informatics (CHI) initiative, the FHA was established within ONCHIT to adopt health interoperability standards, particularly for health vocabulary, data and messaging, and to openly share the standards for use in state and regional efforts.
- Phase I was completed May 2004 and 20 standards have been adopted for use in the federal health-related agencies (HHS, VA, DOD,SSA, GSA, and NIST):
  - *of note to ALTCI, Disability and History and Physical standards have not been adopted, but recommendations are poised for follow-up work.*
- Phase II will focus on implementation, maintenance of the adopted standards, and identification and adoption of new standards.

Data Alliances and RHIOs Background

Background (continued)

- In July 2004, HHS released *"The Decade of Health Information Technology: Framework for Strategic Action,"* which outlined general guidance for the development of a national health information infrastructure.
- On November 15, 2004, ONCHIT issued a Request for Information (RFI) for a Framework for Strategic Action to invite experts to provide structural direction for the development and strategy for a National Health Information Network (NHIN).
- The RFI asked for guidance on many issues, including:
  - Interoperability;
  - Financing models — start up and maintenance;
  - Current barriers;
  - Users; and
  - Identification of a common framework to incorporate community and regional health information exchange organizations.
- RFI responses were due January 18, 2005, and are currently being reviewed; guidelines are expected to begin to emerge over the next few months.

Data Alliances and RHIOs Background

Background (continued)

- Some potential barriers noted from the available responses (NHIN)
  - ***Financial*** — current health care investment and payment policies that do not promote information access, misalignment of financial burden, and return on investment (ROI) among payers, providers and patients, inadequate start-up capital, etc.
  - ***Technical*** — lack of specifications/standards, lack of experience, lack of standard means for patient identification, standard security means, etc.
  - ***Environmental*** — complexity of required transactions, overlap of existing development efforts, etc.
  - ***Educational*** — general lack of public information and understanding (e.g., trust), concern regarding privacy and security, professionals reluctance to use electronic health care data, etc.

Data Alliances and RHIOs Background

Background (continued)

- RHIOs
  - The July 2004 HHS report outlined RHIOs as the entities that will enable the national network to be established.
  - Current ONCHIT working definition: *"Financially viable multi-stakeholder governance entities within communities that oversee the secure exchange of heath care information across care settings and providers."*
  - Current state pioneers include New York, Massachusetts, Indiana, and Tennessee; however RHIOs are emerging in nearly every other state.
  - Currently, local, regional, and statewide efforts vary by goals, roles, structure, and financing.

Data Alliances and RHIOs Background

Background (continued)

- Components of RHIOs
  - Financing;
  - Regulatory Decisions, such as privacy and security standards, core data set, clinical protocols, etc.;
  - Information Technology;
  - Clinical Process Improvement;
  - Incentives, such as P4P, P4U, etc.;
  - Public Relations; and
  - Consumer Participation.
- **Current RHIO funding sources**
  - Funding to date has been provided by two general grant programs:
    - Connecting Communities for Better Heath (CCBH): provides funding and technical support:
      - funding comes from the Health Resources and Services Administration (HRSA) and administered by the eHealth Initiative, a quality, safety, and efficiency-based initiative.
    - The Agency for Healthcare Research and Quality (AHRQ) provides funding in grants to states, communities, and health care organizations to support system linkages and integration.

Data Alliances and RHIOs Background

Background (continued)

- There are multiple integrated data alliances, networks, and regional health information organizations in operation in California. They include:
  - CalRHIO — Regional Health Information Initiative for Support of Development, Implementation, and Application of Health Information Exchange;
  - San Diego Medical Information Network Exchange (SD-MINE) — Health Information Exchange;
  - Santa Barbara County Care Data Exchange — Health Information Exchange;
  - Central Valley — EMR Centric;
  - Ukiah/Mendocino County – Alliance for Rural Community Health — Registry/Integration;
  - Kaiser/CHW/Sutter — Health Information Exchange;
  - Santa Cruz — Document Exchange, Registries;
  - Silicon Valley – Smart Valley; and
  - Sonoma County
- We selected the 2 programs that will likely have the most overlap with San Diego County ALTCI information system planning from which to obtain more information.

Data Alliances and RHIOs
SD-MINE

SD-MINE*

- Countywide health care information exchange initiative, developed more than a year ago through a partnership with:
  - San Diego County Medical Society Foundation,
  - California Health Alliance,
  - The National Patient Safety Institute (PSI),
  - The San Diego Center for Patient Safety,
  - Quest Diagnostics,
  - SureScripts,
  - Several health plans, and
  - Corporate sponsors.

* *Information derived from website and discussion with Dr. Stephen Carson, MD, Chief Medical Officer, San Diego County Medical Society Foundation.*

Data Alliances and RHIOs
SD-MINE

SD-MINE (continued)

- Overall goals include:
  - Provide a common platform for the delivery of medical information at the point of services,
  - Assist providers and hospitals to improve workflow,
  - Decrease administrative expenses,
  - Improve quality of care for patients, and
  - Provide a source for provider and patient education materials.
- SD-MINE partnered with California Institute of Information Technology and Telecommunications to provide the technological platform for “real-time” health care information exchange to all county providers.

Data Alliances and RHIOs
SD-MINE

SD-MINE (continued)

- Features of SD-MINE include:
  - Centralized access via a single system to link all patient services sites in San Diego County, including physician offices, hospitals, pharmacies, labs, and radiology centers;
  - Patient-centric electronic prescribing;
  - “Preferred “ practice management and/or EMR systems for physician reference for technology adoption;
  - Links to health plans for formulary, eligibility, and benefits information;
  - Free, prescreened patient resource guides and education materials; and
  - Links to “the best of breed” websites for physician education and guidelines.
- Current SD-MINE operational features include:
  - Alerts on disease outbreaks;
  - Directory of health services from the San Diego County Department of Public Health; and
  - Formulary, eligibility, and benefit information from health plans.

Data Alliances and RHIOs
SD-MINE

SD-MINE (continued)

- Financial Support:
  - Currently, SD-MINE is funded for start-up, development, and long-term maintenance; and
  - Future funding may include those stakeholders that realize efficiencies and reduced costs because of the exchange, such as labs, health plans, etc.
- Technology Features via a central platform:
  - Provide physicians with real-time access to clinical data;
  - Allows hospitals and medical groups to link this modality to their existing information sites; and
  - Will allow data exchange across all authorized users.
- The system is scheduled to be rolled out in June 2005, with a goal to have 100 providers using the site by the end of the year.

Data Alliances and RHIOs
CalRHIO

CalRHIO

- CalRHIO is a collaboration of several California health care organizations that officially came together in April 2005, and will electronically link providers statewide.
- Collaborators include:
  - Kaiser Permanente, contributed $1M grant;
  - Sutter Health, contributed $1M grant;
  - WellPointe, contributed $1M grant; and
  - The University of California, contributed $100,000.
- Additional funding will come from:
  - Lumetra, a not-for-profit quality improvement organization;
  - John Muir/Mt. Diablo Health System; and
  - Cedars-Sinai Health System
- The California HealthCare Foundation provided $450,000 for office space and to sponsor 5 summit meetings for stakeholders.
- The Health Technology Center is managing the effort.

Data Alliances and RHIOs
CalRHIO

CalRHIO (continued)

- CalRHIO will promote local, regional, and statewide projects that facilitate secure sharing of patient data.
- Project components include:
  - Information sharing and a platform for collaboration through project office — vendor HeathTech, working groups, website, and communications;
  - Develop research and analysis for policy, value proposition for state investment in health care IT, governance models for health information exchange, legal issues, business models for financing, etc.; and
  - Conduct State Summit meetings.
- Mission:
  - *"A collaborative, statewide initiative in California to improve the quality and efficiency of health care through the use of information technology and the secure exchange of health information."*
- Vision:
  - *"Health care that is safe, of high quality, and efficient, in an information-rich environment that meets the needs of consumers, patients, providers and others in California's communities."*

Data Alliances and RHIOs
CalRHIO

CalRHIO (continued)

- The primary goals include:
  1. To incrementally build a statewide data exchange for California;
  2. To implement projects that build systems for data exchange, and demonstrate their feasibility and utility;
  3. To build financial and business models;
  4. To ensure that California's data exchange projects are consonant with national technology platforms and networks;
  5. To support the development of private and public policies;
  6. To support the development of private and public policies regarding privacy, confidentiality, access for safety net providers, and inclusion of underserved populations;

Data Alliances and RHIOs
CalRHIO

CalRHIO (continued)

7. To identify legislation and regulation necessary for statewide data sharing;
8. To encourage business, health care, and policy leaders to create private and public policy agendas and funding for data exchange and IT investment;
9. To facilitate creation of common governance, process, technology, and other elements needed for regional and statewide date exchange organizations;
10. To help organizers of local and regional data exchange efforts within California to work toward common goals and share their knowledge; and
11. To ensure safety-net provider and underserved population participation in data exchange and IT investment.

- Current CalRHIO projects include:
  - Linking hospital emergency departments across the state;
  - Defining the infrastructure necessary for statewide health data exchange;
  - Supporting enhanced safety in medication management;
  - Improving the efficiency of administrative functions for plans and providers; and
  - Giving consumers more direct access to health information in Personal Health Record.

Data Alliances and RHIOs
Summary of Major Findings

Summary of Major Findings

- A Federal IT agency structure and oversight body is in place; however, no Federal guidelines exist at the moment.
- Messaging and general interoperability standards are being developed for use with Federal agencies, providing guidance for RHIOs.
- RHIOs are expected to enable the national heath care information structure by "building public trust in health care IT, as well as to protect privacy, integrate security techniques, and align financial incentives," stated Dr. David Brailer, Chief, ONCHIT, at the launch of the CalRHIO.
- CalRHIO can provide business and financial models, as well as assistance to integrated networks for data exchange/sharing, etc.
- There are multiple California health care data exchange models that can provide lessons learned and viable approaches to ALTCI.
- SD-MINE has a rapidly developing data exchange model that will be critical to include in a LTC integrated network.

VII. Other State LTC Integrated IT

Other States
Background — Integrated Program Findings

Background

- Seven (7) other states have integrated acute and LTC programs;
- We conducted interviews with 2 of these states:
  - Arizona — *Arizona Health Care Cost Containment System/Arizona Long-Term Care System (AHCCCS/ALTCS)*; and
  - Massachusetts — *Mass Senior Care Options*.
- Both programs utilize integrated managed care deliver systems.

Other States
Arizona — AHCCCS/ALTCS

Arizona*

- Arizona ALTCS was established in 1989.
- ALTCS Program Features:
  - Funding — Medicaid;
  - Population — all Nursing Home Certifiable Medicaid Eligibles; and
  - Enrollment is mandatory.
- Information/Data Access:
  - AHCCCS/ALTCS hosts an on-line eligibility system that is available for all registered providers to access to verify eligibility and enrollment for all AHCCCS members;
  - This same subsystem contains Arizona's Pre-Assessment Screening (PAS) results, which are the ALTCS eligibility results, accessible to AHCCCS/ALTCS and their contracted health plans (for their enrolled members); and

***** *Information obtained from Alan Schafer, ALTCS Manager, Division of Health Care Management, AHCCCS.*

Other States
Arizona — AHCCCS/ALTCS

Arizona (continued)

- A second system, the Client Assessment Tracking System (CATS), available to the health plan and AHCCCS/ALTCS, stores the additional information that is entered by the member's health plan:
  - The member's assigned case manager (ID# and Name);
  - Current placement detail and history (i.e., own home, assisted living, other community setting, or Nursing Home); and
  - Each member's cost-effectiveness calculation.

- Business Requirements — Arizona requires each contracted health plan to maintain a website that meets certain specifications and contains:
  - Complete provider directory;
  - Provider manual (covers claims submission, member accessibility, and other standards);
  - Member handbook (explains how to access services, rights and responsibilities, grievance and appeals process, and other elements);
  - Health plan formulary (i.e., which drugs are covered); and
  - Claims status inquiry for providers.

Other States
Arizona — AHCCCS/ALTCS

Arizona (continued)

- Future System Plans:
  - Arizona currently does not have an integrated information system for the ALTCS program; and
  - Arizona is in the very early stages of developing the scope and functionality of an integrated database that will consist of a flexible platform for storing data to be accessed by a wider variety of users:
    - The database will be developed and maintained by the State/AHCCCS.

Other States
Massachusetts Senior Care Options

Massachusetts*

- Massachusetts Senior Care Options was established in 2004.
- Features:
  - Funding — Medicaid/Medicare;
  - Population — Aged, Blind, or Disabled (ABD);
  - Age — 65+; and
  - Enrollment is voluntary.
- Information/Data Access:
  - The state maintains an eligibility/enrollment system that contains minimum data set (MDS) or MDS HC (home care) assessment information;
  - The State's website contains basic Medicaid/Medicare information, but does not currently include a comprehensive provider network for their contracted senior care organizations (SCOs); and
  - The State does not maintain member/advocate disease management/education materials on its website.

* *Information obtained from Diane Flanders, Director, Massachusetts Senior Care Options.*

Other States
Massachusetts Senior Care Options

Massachusetts (continued)

- Business Requirements:
  - The SCO-contracted health plans are required to submit the aforementioned MDS or MDS HC assessment information to the State upon a member's initial enrollment and submit updates every 6 months:
    - This information is used to drive capitation rating categories to be assigned to individual members, and
    - Two of the three SCO contractors also post the MDS and/or MDS HC data to their centralized enrollee record, although this is not currently a required component by the State; and
  - Centralized Enrollee Record (CER) — the contracted health plans are also required to maintain a single, centralized, comprehensive record that documents the enrollee's medical, functional, and social status, accessible by the SCO's on-call clinician, and transferable to the external provider network:
    - The CER contains:
      - enrollee identifying information;
      - documentation of each service provided, including the date of service, the name of both the authorizing provider and the servicing provider (if different), and how they may be contacted;
      - multidisciplinary assessments, including diagnoses, prognoses, reassessments, plans of care, and treatment and progress notes, signed and dated by the appropriate provider;

Other States
Massachusetts Senior Care Options

Massachusetts (continued)

- laboratory and radiology reports;
- prescribed medications, including dosages and any known drug contraindications;
- reports about the involvement of community agencies that are not part of the provider network, including any services provided;
- documentation of contacts with family members and persons giving informal support, if any;
- physician orders;
- disenrollment agreement, if applicable;
- Enrollee's individual advance directives and health care proxy, recorded, and maintained in a prominent place;
- plan for emergency conditions and urgent care, including identifying information about any emergency contact persons; and
- allergies and special dietary needs.

Other States
Summary of Major Findings

Summary of Major Findings

- Both state LTC integrated programs maintain electronic LTC data/information that is derived from the state and the contracted health plans and made accessible to providers and agency staff.
- Both programs maintain electronic eligibility information that is accessible to providers.
- Massachusetts Senior Care Options provides MDS/MDS HC formatted data and EHR-like data for providers and agency staff.
- Arizona ALTCS maintains electronic social/demographic status information, health plan documents such as provider and member handbooks, pharmacy formulary, claims status, etc.
- Neither plan maintains disease-specific, electronic patient/consumer patient education materials.

VIII. Recommendations

Recommendations
Conclusions — Recap

Conclusions

- Consumer/advocates and providers currently use the Internet to exchange information with each other.
- State and local agencies are the least “connected” of the stakeholders surveyed.
- Consumer/advocates, providers, and agencies each expressed a desire for electronic, centralized access to heath care information.
- Agencies and health plans have the largest capacity for storage of electronic data.
- The only data currently available, and in the approved format for data exchange and sharing, is claims encounter and eligibility data from the health plans.
- The health plans are able to conform to federal standards for exchanging the available data.

Recommendations
Conclusions — Recap

Conclusions (continued)

- Other state LTC initiatives make information available to providers and consumers through a combination of State-sponsored websites and by establishing minimum data exchange and access standards for contracted health plans.
- Other state LTC initiatives maintain additional data available for exchange; however, they are not exchanging this data, but making it available via non-integrated websites.
- In general, states do not have robust consumer/advocate centric components of their systems.

Recommendations
Conclusions — Recap

Conclusions (continued)

- A Federal IT agency structure and oversight body is in place; Office of the National Coordinator for Health Information Technology (ONCHIT).
- Federal standards for messaging, data exchange, etc., have been adopted for Federal agencies and RHIOs will follow these guidelines.
- RHIOs are expected to be multi-stakeholder community entities that perform oversight of the secure exchange of heath care information across care settings.
- California is rich with current starts of integrated exchange systems and an overarching RHIO for guidance and support.
- SD-MINE is a local county data exchange that will include LTC providers and will be critical to the integration of ALTCI's efforts.
- It is not readily apparent that social support services or LTC-specific patient education materials will be maintained at either SD-MINE or CalRHIO.
- San Diego's Network of Care website is currently operational and is unique in it's specific focus on supports for the disabled and aging populations.

Recommendations
Key Issues

Key Issues

- There are several integrated data exchange efforts that are currently being developed in the State of California and one in San Diego County.
- It is likely that one, or several of these efforts, will also partially meet the needs of the San Diego County ALTCI.
- It is crucial that ALTCI determine who, what, and why the integrated health data exchange system is being created and which portions already exist, or will exist, in other integrated systems.

Recommendations
Near-Term

Near-Term

- The following are near-term recommendations that are intended to outline next steps.

1. Develop a strategic plan for clinical, support services, technology, finance, legal, governance, and communications for a phased-in approach:
   a. Define shared vision, mission, goals, and objectives for the initiative;
   b. Prioritize functional features for development;
   c. Determine the general function and focus of the system (e.g., will it be a source of information, the architect of local health information networks, provider of applications and services for subscribing members, etc?);
   d. Evaluate legal/governance and organizational structure — determine stakeholders that will require some ownership of the process and determine organizational structure;
   e. Prioritize stakeholder groups interests to be included for initial development and overall infrastructure development; and
   f. Develop stakeholder communication plan.

Recommendations
Near-Term

Near-Term (continued)

2. Identify and outline the available assets of other integrated networks — conduct an *overlap and gap* analysis:
    a. Establish contacts with authorizing body and determine the data/information to be collected, integration points, etc., at SD-MINE;
    b. Establish contacts with CalRHIO, attend summits, and utilize their guidance and modeling for business planning and financial modeling; and
    c. Identify areas of potential overlap with SD-MINE to avoid redundancy (i.e., accessible patient education materials, benefits information, etc.) to integrate with ALTCI and avoid redundancy in compliance with CalRHIO and Federal standards.

***This is a critical juncture at which to stop and determine whether there is a significant overlap in the features and functions that an ALTCI-supported system would perform when compared to SD-MINE, CalRHIO, and any other integrated, or data-sharing system that is currently being developed for use.*

ALTCI must ask at this point: "Is there enough information to which centralized access must be provided by ALTCI to meet the needs of its users, or can it be obtained by stakeholders through another source?"

If the answer is "yes" to the second part of the question, then the following recommendations may be moot for the support of a fully-sponsored ALTCI integrated health data exchange system, and may only apply to those data or information that are not supplied at another centralized source.

Recommendations
Near-Term

Near-Term (continued)

3. Develop Business Model:
   a. Establish RFSQ requirements for contracting ALTCI health plans;
   b. Review business models, value propositions (ROI), and financial structures from other California state integrated networks, such as Santa Barbara;
   c. Identify potential funding structures and sources of support for start-up and implementation — financing model;
   d. Determine if financial participation by members is an option for start-up; and
   e. Outline capital requirements for planning, infrastructure development and start-up — cost model.

Recommendations
Near-Term

Near-Term (continued)

4. Technical Model:
   a. Determine the data fields that are available for use for exchange;
   b. Determine whether a data warehouse/decision support system would be useful to develop for centralized access and prioritize development;
   c. Identify functionality and minimum requirements for data information exchange to be added to the ALTCI health plan RFSQ;
   d. Determine other types of features and uses that the system must sustain;
   e. Evaluate the current Network of Care system, developed and maintained by San Diego, for its application and use as a portal into the emerging system;
   f. Evaluate need for patient identifiers once users and integration is established; and
   g. Maintain watch for federal guidelines release for national infrastructure, federal standards for privacy and security for integrated systems, RHIO, and SD-MINE developments and incorporate.
5. Legal Issues:
   a. Determine the exchange participants network; and
   b. Determine the types of agreements that are necessary to facilitate information exchange and protect public interests.

Recommendations Long-Term

- The long-term recommendations assume selection of a vendor and implementation. The following recommendations are intended to position ALTCI for longer term utilization, maintenance, and support of the data exchange.

1. Determine the clinical and social support models for ongoing usefulness:
   a. Identify additional needs for decision support tools, research, etc.;
   b. Outline additional social support model requirements and uses; and
   c. Determine if predictive modeling tools are required by the users.
2. Determine incentive structure:
   a. Identify pay for performance models and determine if they are useful and can be supported by the system; and
   b. Identify pay for use models and determine if they are complimentary to the financial planning structure.
3. Financial Model:
   a. Identify ongoing funding structures and sources of support for maintenance;
   b. Determine new costs or value receipt by users for potential funding;
   c. Outline capital requirements for ongoing operations; and
   d. Establish methodology for ongoing value/ROI calculations — savings model.

Recommendations Action Plan — Phase I

July to December 2005 — Phase I

- Develop a strategic plan, including organizational infrastructure, stakeholder communications, address barriers, and outline all assets.
- Identify and outline the available assets of other integrated networks.
- Develop a business model and approach.
- Develop a technical approach and issue RFSQ; determine if a data warehouse is necessary
- Outline a financial model and potential sources of funding.
- Determine the legal issues and develop an approach to achieve compliance.

January to June 2006 — Phase I

- Begin stakeholder communications and create interest/focus groups.
- Incorporate Federal guidelines and CalRHIO guidance into structure planning.
- Outline clinical and social support model requirements.
- Outline technical infrastructure and determine interfaces with SD-MINE and other integrated networks.
- Finalize overall infrastructure needs, prioritize for implementation by phases, and identify test plan internally, interfaces, and by users; develop training manuals.

Recommendations
Action Plan — Phase II

July to December 2006 — Phase II

- Launch Phase II — initiate implementation and test plan; distribute materials and conduct training.
- Continue organizational communication and infrastructure development; identify ongoing needs and opportunities.
- Plan implementation and identify infrastructure needs for clinical and social support data exchange; reassess users and capabilities.
- Financial model — identify additional users and consider alternative forms of support; develop savings model.
- Begin incentives implementation.

January to June 2007 — Phase II

- Finalize implementation and testing.
- Implement clinical and social support data exchange.
- Implement savings model and calculate savings achieved; revisit financing for new uses and cost model for ongoing support.
- Launch Phase III — ongoing testing, identify integration opportunities, new user opportunities, and additional technical needs.
- Continue ongoing stakeholder communications and incorporate feedback, make adjustments to organizational infrastructure, and continue interaction with other integrated networks and RHIOs to avoid duplication of efforts.